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Edwards H, Gaskill D, Sanders F, Forster E, Morrison P, Fleming R, McClure S, Chapman H

Abstract:

Objective(s): This paper describes one facet of a study to develop and implement a “best practice model” of residential care for older people. The purpose of this facet of the larger study was to describe the current interactional context of a residential aged care facility.

Method: A total of 2,848 observations of resident-staff interactions were made and coded according to Baltes’ observational schedule. Coder inter-rater reliability was maintained at 90% (Cohen’s Kappa).

Results: Residents were alone 40% of the time they were observed. The dominant pattern of staff interaction with residents was to not engage in direct verbal or nonverbal communication or physical contact. The dominant response by staff to resident independence was to make no response. The dominant staff response to resident dependence was to support that dependence.

Conclusions: Residential aged care practice continues to be focused on technology and tasks and interactions between residents and staff continue to be dependency-supporting.

Introduction

Approximately 7% of Australia’s aged population live in residential care facilities and almost half of these residents are aged 85 years and over [1]. The system of care for older people in Australia has undergone significant reform since the mid 1980s. Federal government policies and initiatives have resulted in changes to organisational arrangements along a continuum of care. There has been a shift in expenditure patterns, a raised awareness of the rights and needs of older people, an emphasis on “ageing-in-place”, and increased attention to the provision and monitoring of quality outcomes. For further detail see for example [2-4]. The policies outlining

objectives for residential care and the standards of care which nursing homes and hostels are required to attain in order to be granted accreditation and assure quality are of particular relevance to this study.

The Aged Care Standards and Accreditation Agency, which was established under the Aged Care Act 1997, supervises the quality of residential aged care. The quality of care provided by a service is evaluated against four accreditation standards: Management systems, staffing and organisational development; Health and personal care; Resident lifestyle; and Physical environment and safe systems. Each of these four standards is further divided into expected outcomes or “expected standards” with explicit criteria for each outcome. In all there are 44 “expected standards”, see for example, [1, 2, 5, 6]. The major objectives and the basic standards for residential aged care are thus clearly delineated, and encompass a broad *quality of life* approach to care. However, providing objectives and standards is but the first step towards assuring quality of care; assurance requires evidence. Demonstrable evidence is required to guarantee that quality residential aged care is reality and not simply rhetoric. This begs the question of whether or not the objectives and standards have had any effect on residential aged care practice.

Past practice

Practice in residential aged care facilities has largely followed the bio-medical model of care [7]. The bio-medical model, with its primary focus on disease and illness, regards people as passive recipients of services, and is defined more by the purposes of the professional community than by the contexts in which people live their lives [8]. Within this model of care, the nature of the relationship between the provider and the consumer is paternalistic (or maternalistic): that of a benevolent parent (the expert provider), who knows the best treatment for the compliant child (the consumer) [9]. However, paternalism has been extensively documented to be insensitive to a variety of citizens' needs [9] and it also ignores the paradox that those most incompetent and in need, require more, rather than less, control over their own lives [10]. Paternalism serves not only as a barrier to people maintaining control over their lives - their independence, but also as a barrier to staff promotion of independent behaviour [7].

The existence of such non-therapeutic relationships in a health care setting seems ironic in view of the abundance of literature concerning the importance of a therapeutic or caring relationship in the health care professions, for example [11-13]. Within nursing, great therapeutic value is placed on the nurse-patient relationship, which is underpinned by the concept of “therapeutic use of self”, a concept that recognises the benefit of interpersonal interactions between nurse and client [12]. Interpersonal interactions have been the focus of numerous research investigations in various contexts.

A number of research studies have examined communication and interaction between residents and staff in residential aged care facilities. It has been argued that health care delivery can be viewed as a communicative act which highlights the interactional nature of caring [14]; that communication forms the lynchpin for understanding the interrelationships among social support, psychological well-being and physical health [15]; and that the process of interpersonal communication is at the centre of the ageing process [16]. Further, as interaction is necessary to assess needs, to negotiate plans of action and to evaluate care it arguably provides an appropriate medium by which to examine processes of care [17]. It is clear that interactions or interpersonal processes form a significant component of the health caring role, and deserve special attention during the ageing process in terms of coping with the myriad losses associated with ageing and of maintaining health [18]. Interaction is also a prerequisite for participation and involvement in health care decision making concerning consumers.

However, several studies report that communication between staff and older people in residential care is infrequent, of short duration and primarily oriented to physical care [19-21]. In-depth analyses of the content of conversations between staff and older residents confirm that most interactions focus on the technical and physical aspects of care, with the older person's dependence maintained by staff use of interpersonal control strategies such as interrupting and directing [22-25]. It appears that by focusing on “getting the tasks done” few opportunities arise for staff to have socially oriented communication with residents. Moreover, staff do not appear to make use of social opportunities when they do arise.

Research indicates that the most consistent behaviour pattern between staff and residents is resident dependency followed by staff support for that dependency [26-31].

Moreover, when independent behaviour by an older person does occur, it tends to be ignored by staff. Dependent behaviour from older residents elicits prompt and reliable supportive responses from the staff, which involved not only care but also social attention. Thus, although dependent behaviours may result in diminution of self-care, they can provide residents with a means of gaining social contact and a strategy for exerting control over their environment. The desire of older people to exert control over their environment is not questioned, but what is questioned is whether dependent behaviour is the appropriate vehicle by which to exert control. Baltes [31] argues that many older people select to be dependent in certain domains of their life so that they can offset diminished reserves of energy and resources and be independent in other domains. Processes of care need to provide older people with a balance between social control in situations of dependence as well as independence [28]. A significant consequence of research in this area has been confirmation that dependent behaviour in older people can be modified [26-32]. It is important to note that it is not dependence *per se* that is being contested, but rather the behaviour patterns that maintain and promote dependence. The challenge for quality residential aged care is how to uphold and advance independence for as long as possible.

Whilst there is a broader literature related to dependency issues in aged care (see for example, [33]), the phases of this study were for the most part based on the extensive observational research of Baltes and colleagues. The project: *Maximising independence and autonomy for vulnerable older people in a residential setting: facilitating best practice*, was undertaken by researchers within a university based School of Nursing in collaboration with staff at an aged care facility.

Overview of the project

The general goal of the project was to bring about a significant change within a specific context that would enhance residential aged care practices. The specific purpose was to develop and implement a “best practice model” of residential care for older people. The action plan included a workplace psycho-education program, an intervention similar to that developed by Baltes [31]. Although the model was implemented and evaluated within a specific nursing home, it is suitable for adoption to any long-term care setting for older people.

The project was conducted in collaboration with a 78 bed aged care facility in Brisbane, Australia. The study comprised five phases: 1). Consultation, liaison and planning, 2). Data collection; 3). Implementation; 4). Evaluation; and 5). Development of a resource kit. This paper addresses a section of Phase 2 of the project. During Phase 2, we collected baseline data on resident-staff interaction to establish the extent to which residential aged care practice continued to be focused on technology and tasks and if interactions continued to be dependency-supporting. In view of an Action Research approach, no differentiation was made between occupational groups of staff during this phase.

Methodology

The project drew on the principles of Action Research [34, 35]. An action research approach is contextual and generative, rather than generalisable. However, the approach identifies many particulars that can be adapted, modified, or extended and used in other contexts.

Context

The setting for the study was a 78 bed residential aged care facility in Brisbane, Australia. The facility is divided into three floors. The ground floor has residents with palliative and high dependency needs, the second floor has residents with dementia and the top floor has residents with the least physical and/or cognitive impairment. For this reason, residents on the top floor were approached to participate in the research. Staff movement between floors was minimised during the study.

Participating residents

Twenty residents (or their next of kin or legal guardian) consented to participate. All were women with a mean age of 84 years ($SD=7.05$). The majority of participants (17) had high care needs as indicated by their categorisation of either 1 or 2 on the Resident Classification Scale [36]. This scale is used to determine care needs and the subsequent level of Commonwealth Government subsidy. Classification is based on assessment of ability in various activities of daily living and clinical, personal care, communication, social and emotional support needs. A classification level of 4 or lower is required for nursing home care approval and funding.

Staff

All the staff members of the facility (N=68 nursing, therapy and domestic) were fully informed about the study by the project officer and were invited to participate in the study. Detailed written participant information sheets were also distributed. The staff members observed interacting with residents in this phase of the study were generally nursing staff (N=51). Other staff interacting with the residents included domestic staff (14) and ancillary staff (3).

Ethics Approval

Permission to conduct the study was obtained from the proprietor of the aged care facility. Ethical approval was obtained from the Ethics Committee at Queensland University of Technology. The project officer fully informed the residents, families and staff about the study and obtained written consent from those agreeing to participate.

Data collection - Interactions

Observations of interactions were made and coded according to Baltes' observational schedule [31] (see Table 1). This schedule provides six categories for observing resident behaviours and six categories for observing staff behaviours during resident-staff interactions. These data were collected to identify the independent and dependent behaviours among residents and staff at the facility. Two nurse researchers and the project officer, who was also a nurse, worked together to clarify and further refine the definitions of the behavioural categories.

Insert Table 1 about here

Six videos were made of resident-staff interactions and then used for training purposes. This enabled the coders to develop consistency and reliability. To ensure inter-rater reliability, training continued until the percentage agreement between the three researchers reached 90% (Cohen's Kappa). The three researchers then undertook pilot observations in context and were able to maintain a 90% agreement on the ratings.

Residents were observed over five days during the times 7am-9am, 11am-1pm and 4pm-6pm. These three times were chosen not with the intent of examining

differences but because they were the periods when most care practices were undertaken and resident-staff interactions were most likely to occur. The observations were made by three registered nurses trained in the use of Baltes' observation schedule (see Table 1) Observations were recorded on spreadsheets on a hand held mini computer. Observation was as unobtrusive as possible but at a distance that allowed observation of both physical and verbal interactions. The observations were continued if the resident moved to other rooms. To minimise the Hawthorne effect, the researchers spent a lot of time in the nursing home observing care practices, so that residents and staff became used to being observed

Each participating resident was observed once each day at a randomly selected time during the scheduled times. Participants were randomly selected for observation for a total of 15 minutes. At each 30 second interval the behaviour of the resident and any social partner (staff, other residents, family) who was within two metres of the resident was recorded as a *behavioural or interaction event*. Behaviours of social partners within two metres of the resident were recorded in relation to the resident being observed. A total of 2,848 behavioural events were observed in the pre-program observational data collection.

Results

Resident behaviours (N=2,848)

Residents were found to be alone for 40% (n=1140) of the observations. Only 17% (n=480) of observations involved staff, while 29% (n=832) involved other residents. 14% (n=396) of the observations involved a combination of residents, staff and visitors or family. When the residents were alone the most frequently occurring behaviour was non-engagement (49%), followed by independent self-care (28%). Residents were constructively engaged in only 10% of the interactions (see Figure 1).

Insert Figure 1 about here

When residents were not alone (that is, when they were within two metres of staff, other residents or family), they were non-engaged (eg. staring at the wall) for 36% of the observations; performing self-care (eg. dressing without assistance) during 32% of observations; and constructively engaged (eg. chatting, watching TV, reading) for 21% of observations (see Figure 2).

Insert Figure 2 about here

Staff behaviours

When a staff member was present during an observation, the most frequent staff behaviour was no response to the resident (63%). Staff behaviour tended to support resident dependency during 13% of observations and supportively engaged the residents during 12% of observations (See Figure 3).

Insert Figure 3 about here

Staff-resident behaviours

The data on the pattern of staff response to a resident when they were alone with the resident (ie no-one else present) revealed some interesting interaction patterns. When residents were constructively engaged the staff were either supportive (41%) or made no response (49%); when residents were non-engaged the most significant staff behaviour was to make no response (89%); when residents displayed independent behaviour in their self-care the staff were more likely not to respond (79%) but when they did respond they tended to support independence (12%) or supported dependence (11%). Finally, when residents displayed dependent behaviour the staff generally supported this dependence (87%).

Summary of main findings

The residents who participated in this project had high care needs and this is consistent with requirements regarding admission to aged care facilities. They suffered a range of cognitive and physical impairments and were dependent on staff for much of their care. The residents were typical of those in aged care facilities in that they were, on average, over 80 years of age and female.

An unexpected and clinically important finding was the amount of time that residents spent alone with no staff, visitors, relatives or other residents around them. Residents were alone 40% of the time they were observed. During these times they were likely to be either inactive or independently attending to their hygiene needs.

When residents were with staff, other residents or family, they were still likely to be either inactive or attending to their hygiene needs. However, at times they were reading, watching television or conversing.

Another important finding was the dominant pattern of staff behaviour that occurred when staff were with residents. For more than half of the staff-resident interactions, staff engaged in no direct verbal or nonverbal communication or physical contact with residents. When contact and communication did occur, it was supporting either independent or dependent activities on the part of residents. The dominant response by staff to resident independence was to make no response. The dominant response to resident dependence was to support that dependence.

Discussion

The observational data supported findings from previous studies that showed communication between staff and residents in aged care facilities to be infrequent, of short duration and oriented to physical care [19-21]. The poverty of interaction is of serious concern in view of health care primarily being a communicative act, with communication a vital link between social support, well-being and physical health, and thus successful ageing [14-16, 18]. Furthermore, processes of care such as assessment, negotiation, collaborative planning, and evaluating all require interaction [17]. The low level of interaction in residential care raises serious questions about not only the effectiveness of the processes of care but also the quality of the care and the level of resident participation in that care.

Whilst standards in aged care are important, best practice requires exceeding basic standards. Maintaining effective and quality care requires more than monitoring standards. Within the aged care sector this may necessitate the ongoing evaluation and development of more specific micro-elements of communication and participation in the care process. New indicators may be needed to ensure that effective and quality processes of care are delivered. Such indicators could identify best practice guidelines to ensure quality care.

The patterns of the observational data support previous research [28], which found that care staff tended to ignore independent behaviour but supported dependent behaviour. The patterns of supporting dependence are deeply entrenched in aged care and more education and training may be needed to assist staff to develop new ways of responding to residents. Achieving such changes in residential aged care settings will require changing long entrenched work practices and attitudes. Changing staff-resident communication patterns to maximise resident independence will not be easy,

nor will it happen overnight. Such change has to be seen as a long-term goal requiring commitment from all stakeholders and re-education measures such as those that stimulate staff to discuss, examine and change their practices. It will also require the allocation of relevant resources.

The findings reported in this paper need to be interpreted in light of both the limitations and the purpose of the study. In this phase of the project, limitations may lie within the methods used to gather information. The collection of naturalistic observational information may have prevented the participants from carrying out their activities in the usual way. Further, although preventative measures were taken, the issues of observer neutrality and inter-rater reliability must be considered.

The purpose of this phase of the project was to ascertain the current resident-staff interactions within a specific context. The results are intended as base line information against which an intervention can be evaluated. That is to say, the results are intended to generate further questions and explorations rather than be generalised to other populations. Thus, the small, non-random sample size of both residents and staff does not limit the importance of the findings as they apply to the local context under investigation. Indeed, the findings from this study have important implications for residential aged care practices in any context and their dissemination will hopefully generate interest and debate and eventually further questions in other settings. Finally, it is important to reiterate that it is not dependence *per se* that is of concern; the challenge for quality residential aged care is how to uphold and advance independence for as long as possible.

Conclusion

The findings indicate that interactions between staff and residents continue to be dependency-supporting. Practices in residential aged care facilities continue to follow the bio-medical model of care in which relationships between residents and staff remain paternalistic, encouraging child-like dependence and notions of being helped and protected. That paternalistic models of residential care still exist in spite of the clear message from the numerous government initiatives and policies aimed at promoting greater autonomy for the elderly in aged care facilities. These findings have important implications for residential aged care practice. Quality residential aged care will not be reality until issues related to independence, autonomy and control and

their impact upon resident wellbeing are uncovered and explored, and strategies put in place that maintain and promote independence for as long as possible.

Key points:

- Whilst standards in residential aged care are important, best practice requires exceeding basic standards.
- Assuring effective, quality residential aged care requires more than monitoring standards – it requires evidence.
- At the time of this phase of the project, and within the context of the study, residential aged care practice was focused on technology and tasks and interactions between staff and residents were dependency-supporting.
- The challenge for quality residential aged care is how to uphold and advance independence for as long as possible.

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Table 1. Baltes' Observation Schedule for Resident Interactions

RESIDENT BEHAVIOURS	
Constructively engaged behaviour of resident.	Unrelated to personal maintenance (letter writing, conversing, watching TV, reading).
Destructively engaged behaviour of resident.	Quarrelling, hitting, throwing food or screaming.
Non-engaged behaviour of resident.	Staring at the wall.
Independent self care behaviour of resident.	Resident attends hygiene/self-care without assistance, or resident intent to accomplish these tasks unaided.
Dependent self care behaviour of resident.	Resident requests or accepts assistance in hygiene/self-care. Can include refusal to perform such tasks.
Sleeping.	
STAFF BEHAVIOURS	
Engagement supportive behaviour of staff.	Behaviors that supports pro-social behaviour in the resident.
Non-engagement supportive behaviour of staff.	Behaviors that encourages or elicits non-engagement or cessation of resident behaviour.
Independence supportive behaviour of staff.	Behaviors that encourage/praise or elicit/instruct/suggest resident self-care activity.
Dependence supportive behaviour of staff.	Behaviors that praise/encourage or elicit/instruct/suggest resident's request for or acceptance of assistance with self-care.
No response.	Staff member is within 2 metres of resident but does not direct verbal or physical behavior to resident.
Leaving.	Staff member, who was within 2 metres of resident, leaves area.

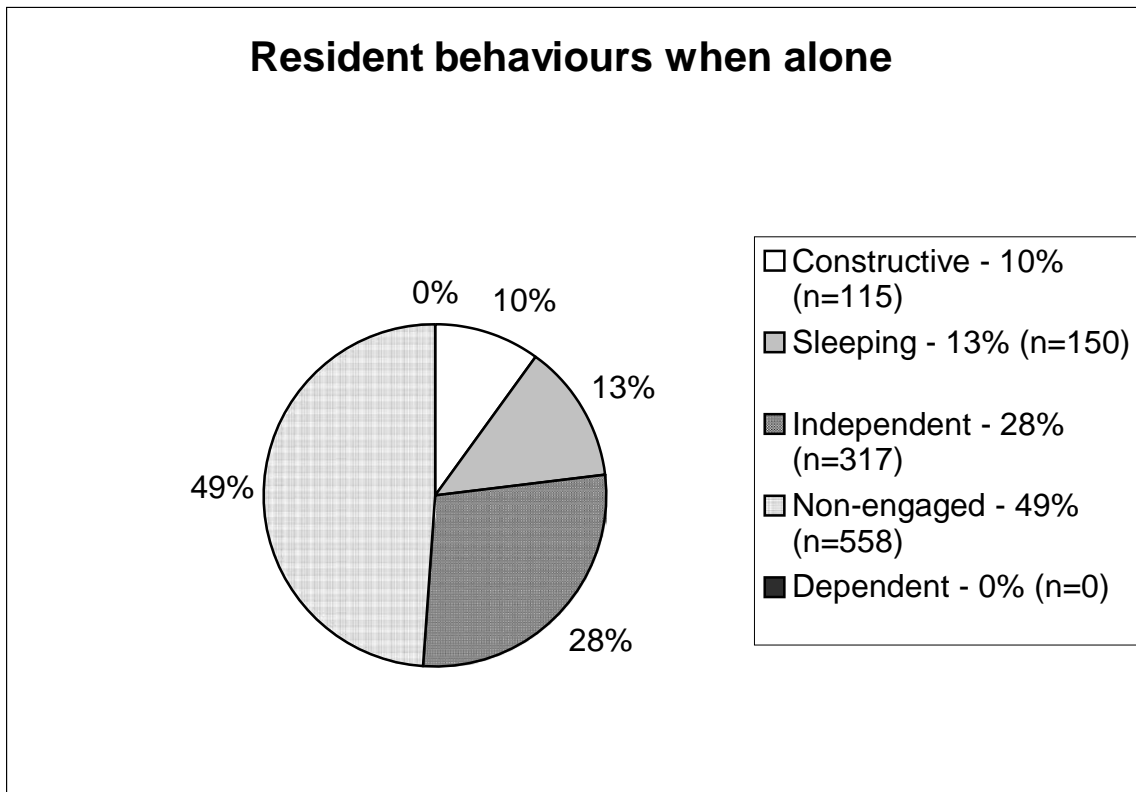


Figure 1: *Resident behaviours when alone (n=1140)*

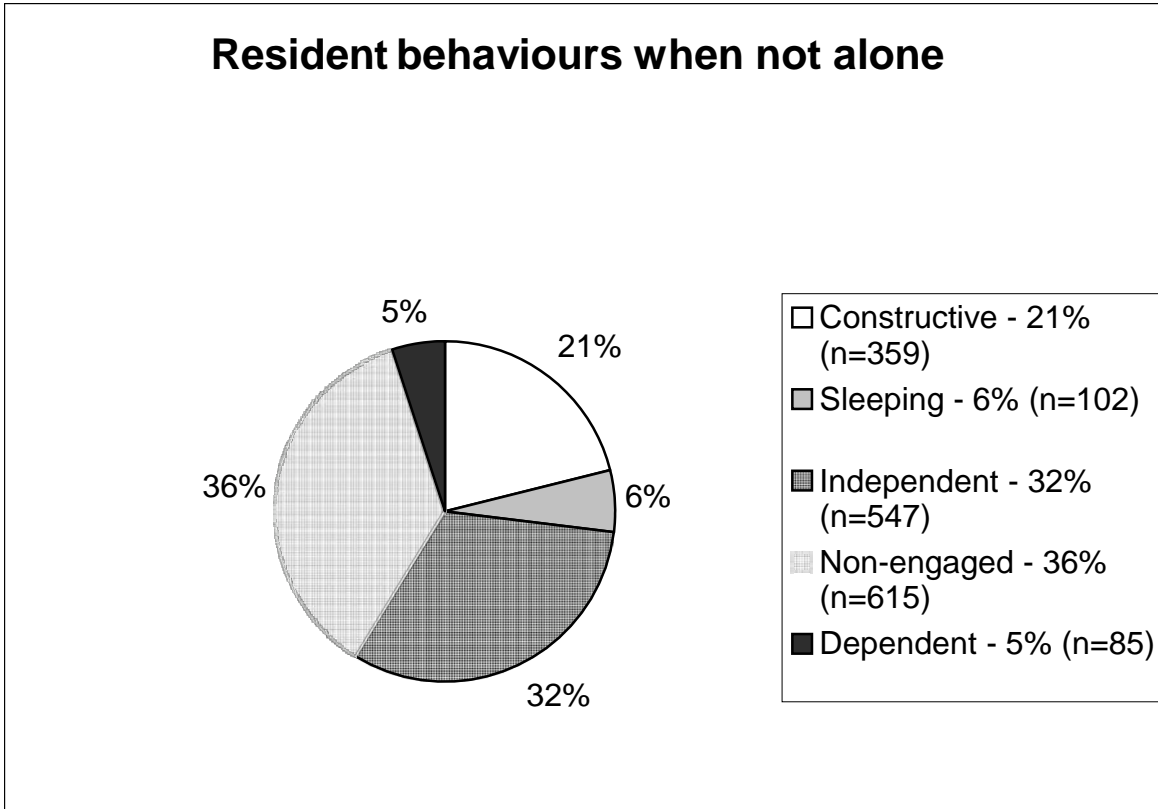


Figure 2: *Resident behaviours when not alone (n=1708)*

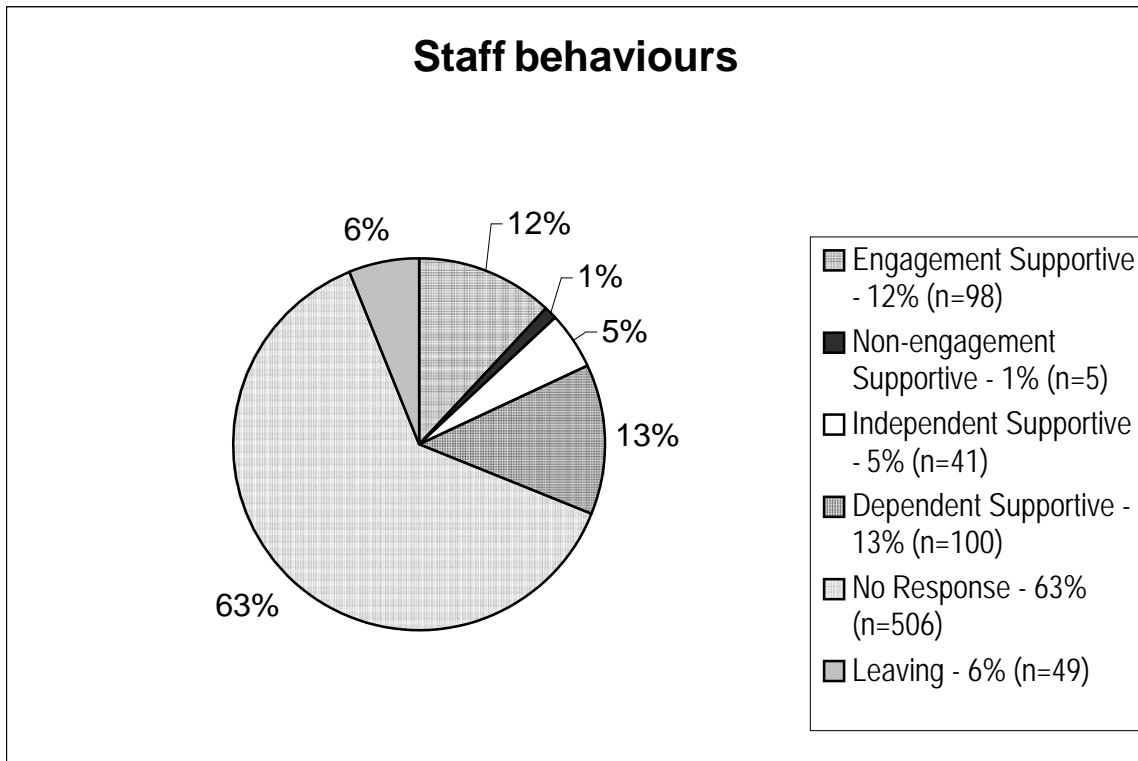


Figure 3: *Staff Behaviours* (n=799)